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VOLUNTEERS IN THE FORMAL LONG-TERM CARE WORKFORCE IN ENGLAND

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About *Social Care Workforce Periodical*

The *Social Care Workforce Periodical* (SCWP) is a regular web-based publication, published by the Social Care Workforce Research Unit, King's College London. *SCWP* aims to provide timely and up-to-date information on the social care workforce in England. In each issue, one aspect of the workforce is investigated through the analysis of emerging quantitative workforce data to provide evidence-based information that relates specifically to this workforce in England. The first issues of *Social Care Workforce Periodical* provide in-depth analyses of the latest versions of the National Minimum Data Set in Social Care (NMDS-SC); for further details on NMDS-SC please visit http://www.nmds-sc-online.org.uk/. We welcome suggestions for topics to be included in future issues.

About the author

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Executive Summary

With an increasing political emphasis on the role of social capital and civic engagement, and within the current climate of financial and economic turmoil, volunteering has assumed a significant position in the map of long-term care. There is currently little evidence around levels and patterns of volunteering within formal long-term care services, such as care homes. In this Issue of the *Social Care Workforce Periodical*, we use recent data from the NMDS-SC to investigate these questions. The analysis is focused on formal provision of long-term care, through services to adults and older people with different types of needs. This Issue uses NMDS-SC data from December 2010, utilising both the provider level and individual level datasets. While the NMDS-SC primarily collects information about the social care workforce, it also requests information on volunteers and voluntary work. While this provides us with an *elected* sample of volunteers within the sector, the volunteer contribution reflected in the NDMS-SC is likely to be an underestimate, for a number of reasons relating to the nature and purpose of NMDS-SC data collection. These factors are discussed further in the Methods section.

Civic engagement takes a number of forms, with volunteering in formal organisations identified as one of the highest levels of engagement. Numerous forms of unpaid long-term care are provided voluntarily, by family, friends and members of other social networks, community or religious groups. However, the focus in this paper is on volunteering within organisations whose purpose is to provide long-term care. This may be seen as an expression of the 'Big Society' mindset, as promoted by the current Coalition government. The National Minimum Data Set for Social Care (NMDS-SC) provides aggregate information on the contribution of volunteers within a large number of organisations[1] providing long-term care in England. We have been able to investigate the personal profile, such as age and gender, of a sample of volunteers, and consider how they differ from (or resemble) the paid long-term care workforce. Because the NDMS-SC data can be analysed at a local level, we were able to link providers' aggregate data to local characteristics: such as level of rurality, average deprivation measures, income and employment levels. We investigated possible associations between the level of volunteering and these local factors. A number of important findings are drawn from the current analysis; in summary:

- A large group of employers indicated that their workforce does not include any volunteers, indicating two main conclusions. The first relates to data reporting accuracy and the second to missed opportunities in engaging local communities and benefiting from volunteers.
- Overall, volunteers constitute only one percent of the total long-term care workforce in England – this is likely to be an under-estimate, due to the nature of data collected by NMDS-SC.[2]

[1] Referred to as 'establishments' within the NMDS-SC
[2] See Methods section for further discussion

- Where there is at least one volunteer working for a particular provider, their contribution can be considerable – in some places they form more than a quarter of the total workforce.
- The voluntary sector (charities and other groups owning and running care facilities or services) attracted most volunteers, and on average benefited from a larger number of volunteers per organisation. Just under half of the organisations with at least one volunteer were in the private sector, and they reported fewer volunteers per organisation.
- Smaller organisations reported being more likely to make use of volunteers than larger organisations, this applied to all sectors including the voluntary (or third) sector.
- Volunteers are more likely to be involved within community care and day care provision than other activities.
- Volunteers are involved in organisations providing services to a range of service users, but they contribute most to services for older people and other adults.[3]
- Volunteers undertook certain job roles more than others, particularly providing counselling, support, advocacy and advice. This suggests that without the work of volunteers, these services would be significantly reduced.
- The NMDS-SC December 2010, data indicate that the majority of volunteers are situated in predominantly rural areas, with the exception of London. For example, prevalence is higher in the North West, the West Midlands and London.
- There were no clear associations between levels of local volunteering and average local deprivation levels, income level or employment level. Some tentative suggestions link the highest level of volunteering to better-off areas.
- In terms of personal profiles, volunteers in long-term care were older, more gender-balanced and less ethnically diverse than the paid long-term care workforce. There were proportionally more young people (19 years or younger) volunteering than in the paid workforce.
- A large proportion of volunteers do not hold relevant qualifications in social care, indicating the potential for attracting volunteers from a broad group of people who may not have work experience within the care sector.

The current analysis and findings provide a unique insight into the contribution of volunteers to long-term care in England. This is particularly important given the growing demand for care, resource constraints and emphasis on the role of civil society in providing support to the wider community. There is clearly great potential for volunteers and their work to enhance social care services and the quality of life of people receiving social care support.

[3] The latter refers to those users of social care with needs other than recognized conditions such as learning disability, dementia, or sensory impairments. For further details see Table 5.

Background

'You can call it liberalism. You can call it empowerment. You can call it freedom. You can call it responsibility. I call it the Big Society.'

Prime Minister David Cameron, 19 July 2010[4]

Social capital and civic engagement are gaining importance given the expanding demand for long-term care and current political, policy and economic priorities. Volunteering is a cornerstone of civic engagement and a key element of social capital, which in turn can be viewed as the fuel of 'Big Society'. Social engagement can take a number of forms, ranging from a simple donation to more active involvement from volunteering time and expertise. This end of the spectrum usually results in more opportunities for the reciprocity and trust deemed so important to social capital (Putnam, 2000). Volunteering can be particularly important after retirement and in an environment of recession and economic hardship, with widespread resource cuts, there is greater 'scope' and opportunity for volunteering. Within the social care sector, volunteer input has long been thought important in developing the mixed economy of welfare (Knapp et al., 1996).

Ideally, volunteering opportunities should provide a balance between rights and responsibilities; however, there is some concern that the current government encouragement of volunteering through the promotion of the concept of 'Big Society' may emphasise responsibilities more than rights. At the same time, the changing nature of the voluntary organisations within the care and welfare sector over the past couple of decades, with the growth of some small local organizations to large national organisations, may provide further challenges in recruiting and retaining volunteers (Broadbridge and Parsons, 2003). In the UK, there has been a shift by some voluntary organisations from 'grass-roots' local activism to engagement with the state at a national level, delivering complex services. It has been argued that this is at the cost of reshaping the relationship between large voluntary organisations and their staff, who traditionally were largely volunteers; from a model at times based on mutual aid, reciprocity and empowerment towards a relationship characterised by inequality and dependence, with high levels of administration and paperwork (Milligan and Fyfe, 2005). This possible shift has been observed in other parts of the developed world. For example, in Australia, Brown and colleagues (2011) found a broad distinction between grass-roots activist organisations and what they term 'welfare state industry' and 'market'-oriented organisations.

Given the current climate of financial austerity, which is likely to affect the level of services and support for public welfare, it is easy to argue for the importance

[4] Big Society Speech, Liverpool. http://www.number10.gov.uk/news/speeches-and-transcripts/2010/07/big-society-speech-53572

of volunteers in the care sector. However, research-based literature about volunteering in the UK is limited, in part attributable to the fact that studies of volunteering do not come under one discipline but cut across a number of them. In general, in most economically developed countries, the majority of volunteers are located in non-profit or voluntary organisations, with a large percentage involved in human services (Wilson et al., 2005; Butler and Eckart, 2007): but human services can be very broadly defined and are not confined to long-term care.

The definition of the role of the volunteer is not fixed and spans from the idea that a volunteer is principally a helper at the side of the trained professional, to the belief that (if well trained) volunteers enhance professional services and may even provide unique services not otherwise available (Cornes, 2007). In most cases volunteers are seen to 'fill the gaps' within services, but they can also help to improve the quality of existing services (Manthorpe, 2007). Capitalizing on the unique contributions of this group of volunteers may enable organisations to expand outreach activities (Hiatt and Jones, 2000), whilst having a significant positive effect on the volunteers' well-being (Greenfield and Marks, 2004). Within the specific domain of long-term care, the opportunity to benefit from volunteers may be constrained by regulations, if tasks are considered to be the responsibility of 'professional' or paid staff.

The 2001 Home Office Citizenship survey data showed a high level of participation in civic affairs in the UK, defined as engaging in at least one of a range of nine representative activities. Eighty-three percent of respondents had participated in civic affairs within the 12 months preceding the survey. However, this 'civic activities' list was wide, including items such as signing a petition or contacting one's local council in addition to volunteering (Prime et al., 2002). The findings indicated that people aged 35 to 49 years, white people, and men were the most likely to participate in civic activities. Based on the Citizen Audit[5] (2000-2001) it is estimated that four million people in Great Britain volunteer their time and labour to formal organisations (Pattie et al., 2003). The same audit showed that people volunteer most often in residential, sports, religious and cultural organisations, suggesting considerable potential for the social care sector.

Volunteering within a formal organization is usually defined as 'highly active' civic engagement, in comparison to 'modest participation' such as contacting a local councillor or belonging to a social club (Crick, 2000; Attwood et al., 2003). Civic engagement is associated with social capital (Putnam, 2002; Andrews, 2009) and can be seen as an essential ingredient in the concept of 'Big Society' – where communities are expected to assume additional responsibilities for the welfare of their citizens. As financial constraints tighten, the demand for volunteers may increase; particularly in the expanding area of long-term care.

[5] The Citizen Audit is a stratified, clustered, random sample of adults in Great Britain aged 18 or over. For more information see http://www.esds.ac.uk/findingData/snDescription.asp?sn=5099

In this report we investigate evidence of volunteering within the formal long-term care sector in England using the latest data from the National Minimum Data Set for Social Care, NMDS-SC: December 2010. However, while NMDS-SC collects information on volunteers and voluntary work, the data related to this group is likely to reflect only a small sample of volunteers within this sector. This is due to a number of interacting factors, including the nature and purpose of NMDS-SC collection as well as the broad definition and understanding of 'volunteers'; these are discussed further in the Methods Section.

Methods

The current Issue of the *Social Care Workforce Periodical* utilises recent data from the NMDS-SC, up to the end of December 2010. Using both the 'provision' and 'individual workers' files, we focus our analysis on organisations providing services to adults or older people (long-term care), and examine the prevalence of volunteers within such organisations.

Skills for Care define a volunteer within the workforce as a someone who performs '*any activity which involves spending time, unpaid, doing something which aims to benefit others (individuals or groups) other than or in addition to close relatives, or to benefit the environment*'. A 'voluntary worker' is defined as '*someone who may receive a small financial contribution towards the time spent*'. Both volunteers and voluntary workers may receive board and lodging or payment of expenses.

We expected the NMDS-SC to provide information on some, but not all, volunteers working in the long-term care sector. What is provided can be considered to be an '*elected sample*'; being those people recognised and considered by providers of social care to fulfil Skills for Care's definition of a 'volunteer' or a 'voluntary worker'. The NMDS-SC primarily collects both aggregate and detailed information on the social care workforce. Completion of the NDMS-SC by providers is not compulsory but there are some financial and training incentives. Due to the nature of volunteering and voluntary work, providers may not consider some such workers part of their workforce and thus may not report them as such. This may be the case particularly if volunteer contributions are not regular or consistent, both in the nature of volunteering role as well as the level and duration of engagement of individual volunteers. Bearing this in mind, we explore the profile, characteristics and possible associations between volunteering and different micro, meso and macro level factors. We first use aggregate information on all workers within these organisations, to explore where and how volunteers contribute to long-term care provision. The provision dataset provides us with information on the type of services provided, usual client group, sector of 'employment' and other organisational characteristics. We then use the 'individual workers' dataset to investigate the profile of a sample of volunteers within the sector.

Given existing evidence linking civic engagement and local deprivation and unemployment levels (for example Baines and Hardill, 2008), we linked an additional dataset to the NMDS-SC to investigate such associations. We used the English Indices of Multiple Deprivation 2007 (IMD, 2007), which are the government's official measure of multiple deprivations at small area level. The Index of Multiple Deprivation (IMD) brings together 37 different indicators, covering specific aspects or dimensions of deprivation: income, employment, health and disability, education, skills and training, barriers to housing and services, living environment and crime. These are weighted and combined to create the overall IMD 2007. The majority of the data underpinning the IMD

2007 represents the year 2005, although some data cover a number of years; for example, an average of 2003-2005. All components of the IMD 2007 can be used to describe deprivation in a particular geographical area.[6] Using unique local area identifiers, we linked these data to the NMDS-SC provision dataset. The data were analysed to examine the relationship between prevalence of volunteering and the level of deprivation of local area. We also examined the association between volunteering in the care sector and both the income and employment sub-scales separately, in addition to the association with the overall IMD.

Another important factor related to both the opportunity for volunteering and the availability of volunteers is whether an area is predominantly rural or urban (European Commission, 2008). This may affect population density and availability of transport. To investigate the possible association between the geographical characteristics of an area and the prevalence of volunteers, we used rural-urban classification down to CSSR (Council with Social Services Responsibility) level (downloaded from the Office for National Statistics (ONS) website, www.ons.gov.uk): three-way classifications of 'Predominantly Rural' (R50 and R80), 'Significant Rural' (SR) or 'Predominantly Urban' (OU, MU and LU) are obtained for each CSSR. The Rural/Urban Definition, an official National Statistic introduced in 2004, defines the rurality of very small census-based geographies. 'Predominantly Rural' areas have from 50 to 80 percent of their population living in rural settlements or large market towns. 'Significant Rural', indicates that a district has between 26 and 50 percent of its population living in rural settlements and large market towns. 'Predominantly Urban' areas are those with at least 50 percent of the population living in urban centres. These data were linked to the NMDS-SC provision dataset and analysed to explore possible associations between whether an area is rural or urban and the level of volunteering in the local care sector.

The individual workers' dataset contains personal and work-related characteristics such as age, gender, reported disability, induction status, highest qualification levels, migration status and source of recruitment. Employers provided detailed information on just over 700 volunteers out of the larger sample identified through the provision file data. We examined the profile of this sample of volunteers and compared it to the overall profile of the social care sector in England using analyses previously published in the *Social Care Workforce Periodical*.

[6] Aggregate data for each local authority were downloaded from the London Health Observatory website (http://www.lho.org.uk).

Findings

Using the NMDS-SC provision dataset (December 2010), we focused on 22,254 establishments that provide social care services to adults or older people with long-term care needs and which reported the number of volunteers within their organisations.[7] Within this group, employers indicated that a total of 769,186 people were working for or with them: this total includes workers on permanent and temporary work arrangements, and reflects both workers who are paid and those working as volunteers or students. The 22,254 employers reported that 7,534 volunteers provide social care services within their organisations. This gives an average volunteer prevalence[8] of just one percent of the total workforce within this large sample of the NMDS-SC.

A large group of organisations reported having no volunteers at all within their workforce (n=21,527 organisations representing 89% of all provisions). This is a large group of organisations and it warrants further investigation. Closer inspection of this group shows that the vast majority of this group of organisations provided an aggregate total number of permanent and temporary workers, while some provided totals of other groups of workers, such as agency and bank workers. There was a large group of 14,086 employers who provided total numbers for permanent staff only. Looking at the latter group, 84 percent were micro or small organisations and these may indeed have no volunteers, or other non-permanent staff, as part of their workforce. There is therefore no clear evidence to assume a systematic error in the data entry process in relation to the total number of volunteers; however, there is still the possibility of inaccuracy of data reporting and the question of whether employers reported all volunteers' contributions. Another group of 1,932 organisations did not provide any information on the total number of their volunteers: this constitutes a large group with 'missing' information where volunteers may be present.

Profile of provisions with at least one volunteer

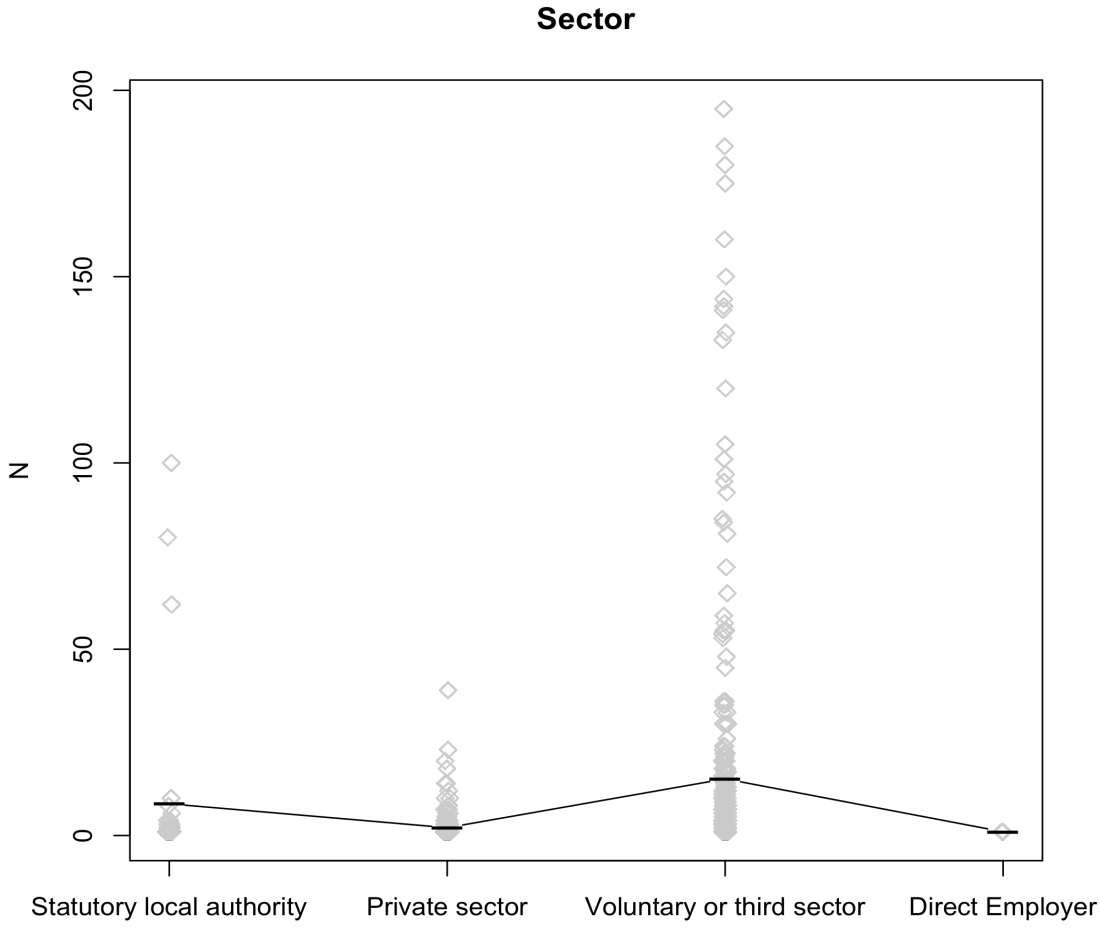
Just over 700 different providers indicated that volunteers are part of their workforce, with nearly half (43.5%) having only one volunteer and 17.5 percent having 2 volunteers; while 17 percent of this group have 10 or more volunteers within their workforce. We examined the group of organisations which identified volunteers as part of their workforce. Organisations with at least one volunteer are almost equally prevalent within the voluntary and the private sector (49% and 45% respectively) with only 5 percent of local authorities reporting volunteer involvement. Figure 1 shows that organisations within the voluntary sector are more likely to have larger numbers of volunteers. On average, the

[7] Excluding 1,932 organisations which did not provide any information in relation to whether they have volunteers within their workforce.

[8] Calculated as the aggregate numbers of volunteers with all organisation providing any information on total numbers of volunteers out of the aggregate number of all workers including permanent, temporary, pool, bank, agency, students and volunteers identified by 22,254 providers of long-term care services who completed the NMDS-SC by December 2010.

mean number of volunteers within organisations with any volunteers is significantly higher in the voluntary sector, at 15.2 volunteers per organisation (median=5), followed by 8.5 volunteers per organisation within the statutory sector, and 2.1 volunteers per organisation within the private sector (median=2 for both sectors). These differences were statistically significant ($F=17.85$, $p<0.001$).

Figure 1 Number of volunteers per organisation by sector, for organisations with any volunteers, NMDS-SC December 2010



When considering organisational size[9] amongst the group of organisations with any volunteers, 60 percent of such organisations are small (10 to 49 workers). However, the mean number of volunteers is largest within medium size organisations (50 to 99 workers), at 13.6 volunteers per organisation (median=3), with equal means of around 7 volunteers for micro and small size organisations (median=1).[10] Only 2 large organisations reported any volunteers as being part of their workforce.

[9] Micro employers = less than 10 staff members, small = 10-49 staff members, medium = 50-199 and large = 200 or more staff members.

[10] The mean is considerably larger than the median due to few organizations reporting a large number of volunteers.

Table 1 shows that most organisations with any volunteers are concentrated within the micro and small sized organisations in all sectors. This is even more evident within the voluntary sector, where only 15.7 percent of voluntary organisations with any volunteers are of medium size compared to 19.6 percent of private sector organisations. Virtually no large organisations across any sector indicated the presence of volunteers.

Table 1 Distribution of organisations with any volunteers by sector and size, NMDS-SC December 2010

	Organisation size				Total number of organisations
Sector	Micro	Small	Medium	Large	
Public sector	9	20	8	0	37
	24.3%	54.1%	21.6%	0.0%	100.0%
Private sector	53	200	62	1	316
	16.8%	63.3%	19.6%	0.3%	100.0%
Voluntary sector	89	194	53	1	337
	26.4%	57.6%	15.7%	0.3%	100.0%

The available data show that the majority of establishments reporting the presence of volunteers are providing residential care (n=382) followed by adult day care (n=111; see Table 2). However, settings with the largest mean (and median) number of volunteers include adult community care and healthcare, albeit that the latter group includes only 11 organisations. While adult residential care constitutes a large proportion of organisations with any volunteers, they have the lowest mean number of volunteers per organisation, at 3.17 volunteers (median=1). While adult community care settings seem to have the largest number of volunteers per organisation, among those with any volunteers, this setting has the highest standard deviation of 44.9; indicating a high variation in the number of volunteers within each individual organisation.

Table 2 Mean number of volunteers per organisation among organisations with any volunteers by type of setting, NMDS-SC December 2010

Type of setting	Average number of volunteers per provider		s.d.	Number of providers	Percent
	Mean	Median			
Adult residential	3.2	1	10.9	382	54.5%
Adult Day	12.2	4	25.1	111	15.8%
Adult domiciliary	9.9	2	23.7	73	10.4%
Adult community care	24.4	6	44.9	92	13.1%
Healthcare	23.0	17	28.2	11	1.6%
Other	13.1	4	19.6	32	4.6%
All organisations with any volunteers	10.7	2	18.1	701	100.0%

The above analyses investigated the sub-sample of organisations which reported having any volunteers. The analysis indicates that both the private and the voluntary sector make use of volunteers; however, when volunteers are present they are more likely to be in larger groups within the voluntary sector. Similarly, more organisations providing adult residential services report the inclusion of volunteers; yet the mean number of volunteers per service is quite low, at 3.2 volunteers per organisation (median=1), compared to a considerable 24.4 volunteers in each of the adult community care services with any volunteers (median=6).

These findings are inter-correlated and reflect the way in which providers are split by sector and setting, with adult residential care being highly likely to be provided by the private sector. On the other hand, adult community care services are likely to be funded by local authorities; but their activities may rely more on the contribution of volunteers. Another interesting finding relates to the relationship between volunteering, the voluntary sector and the size of organisation. Overall, the data indicate that volunteers are more likely to be active within micro to small organisations. Even within the voluntary sector, over 75 percent of the organisations with at least one volunteer are micro to small size. These findings possibly resonate with Milligan and Fyfe's (2005) argument about the tension between voluntary organisations' growth from grass-roots into larger 'corporate' organisations, and the effect this has on the process of recruiting and retaining volunteers. They argue that such organisational development may constrain civic engagement as demonstrated through the act of volunteering, this would worth further investigation.

Level of volunteering in long-term care (LTC)

In this section we focus on the prevalence of volunteers among all organisations providing services for adults or older people with long-term care needs (n=22,254).[11] The overall prevalence of volunteering within the long-term care sector, as extracted from the large sample of the NMDS-SC provision file, is less than one percent (0.98%). The estimate may appear quite low. However, we are attempting to measure volunteering in organisations as part of formal long-term care and this is usually identified as the most high-level type of civic engagement. Of course, there are many types of volunteering in long-term care, including informal, undocumented help at home, providing transport and shopping, which usually take place outside an organised sphere. However, as discussed in the Methods section, there are also some questions around the accuracy of the NMDS-SC in relation to the exact number of volunteers within the formal workforce. In addition to the considerable group of providers indicating no volunteers in their workforce, as discussed above, another large group of organisations did not provide any information on the total number of volunteers (n=1,932 organisations). We expect that the true contribution of volunteers to the formal long-term care workforce is, in fact, larger than one percent; however, there are currently no further data to provide a better estimate. While this overall prevalence is small, the potential usefulness of volunteers within the formal workforce is clear: for the group of organisations with at least one volunteer (n=704), volunteers constitute nearly a quarter of the long-term care workforce within these organisations.

The prevalence of volunteers in the formal long-term care workforce, as measured by the NMDS-SC, can be seen as indicative; and differentials are used here to examine different patterns and associations with a number of characteristics. In this section we examine whether this prevalence is associated with certain meso and macro factors, such as organisational characteristics, type of services provided, and service user groups, as well as the local area effects.

Sector and organisation size

It seems likely that long-term care work itself should be highly associated with attracting and benefiting from volunteers. The private long-term care sector, for example, is a sector with a considerable turnover rate among the workforce and harder working conditions than average, including high workload and unfavourable pay levels (Hussein, 2010a; Hussein, 2010b). By contrast, in the voluntary social care sector, most organisations, particularly smaller ones, continue to link their pay scales to that of local authorities (Cunningham and James, 2009). However, the impact of the current economic climate, combined with the expansion of the government's competitive model for outsourcing social care, is likely to affect the voluntary sector's ability to maintain its capacity of both paid workers and volunteers (Davies, 2009).

[11] Including in the calculations all organisations indicating no volunteers or any volunteers within their workforce.

The data on volunteers presented in Table 3 show that the vast majority (87%) of volunteers are working in voluntary organisations, followed by 9 percent in the private sector and only 4 percent located in local authorities or local authority owned organisations. The data further indicate that the prevalence of volunteers is highest within micro providers (less than 10 workers) at 2.8 percent of their workforce, followed by 1 percent of the workforce in small organisations.

Table 3 Number, distribution and prevalence of volunteers identified in organisations providing long-term care services by sector, NMDS-SC December 2010

Sector[12] of LTC organisation	Number of volunteers	Distribution of volunteers	Total number of workers	Prevalence of volunteers
Public sector	315	4.2%	129,037	0.2%
Private	665	8.8%	472,229	0.1%
Voluntary	6,548	87.0%	166,794	3.9%
Total	7,528	100.0%	768,060	1.0%

Setting and main service provided

Overall, nearly half of the identified volunteers are in community care settings, followed by nearly 20 percent in each of residential and day care settings and 11 percent within domiciliary care settings. However, when examining the contribution of volunteers within each of these different settings, the data show that it is highest in day care settings, where the prevalence of volunteers is 6 percent of total workers. This is followed by community care, where the prevalence of volunteers is 4.5 percent. Overall, the contribution of volunteers to the workforce in both residential care and domiciliary care workforce from this data is minimal, at 0.3 percent.

Table 4 Number, distribution and prevalence of volunteers identified in organisations providing long-term care services by type of service setting, NMDS-SC December 2010

Service setting	Number of volunteers	Distribution of volunteers	Total number of workers	Prevalence of volunteers
Residential care	1,212	19.0%	386,919	0.3%
Day care	1,350	21.2%	22,254	6.1%
Domiciliary care	725	11.4%	225,770	0.3%
Community care	3,091	48.5%	69,350	4.5%
Total	6,378	100.0%	704,293	0.9%

[12] Excluding direct payment employers.

Service user groups

Service users or 'clients' of long-term care are varied and include older people with certain conditions such as dementia as well as others who require support and assistance arising from other co-morbidities. They also include adults with different types of disability or impairment. The NMDS-SC collects information on service users for each of the providers completing the data returns, requesting a selection of user groups from a pre-coded list and allowing the selection of more than one group of users. Out of the 7,534 volunteers identified by the 704 employers, over half volunteer in organisations providing services to older people with 'other needs' (excluding older people with different conditions such as dementia, mental health needs, and learning disabilities, as listed in Table 5). At the same time, over a third of volunteers are in organisations providing care for older people with dementia and mental health needs. The last group is likely to overlap with the first, as care providers usually provide services for a range of older people. The NMDS-SC December 2010 data do not indicate specifically whether volunteers are involved with a particular group of users, but rather that they are situated in certain organisations.

Because the data enable the total number of workers to be identified, as well as the total number of volunteers, in organisations that provide services to different user groups, we were able to use these figures to calculate the prevalence of volunteers in the workforce by each user group. Table 5 (last column) indicates that the highest prevalence of volunteers (3.7% of the workforce) was found in services for 'adults with other needs', followed by 2.8 percent and 2.5 percent for 'carers of older people' and 'carers of adults'. Although the overall prevalence of less than 4 percent may appear low, this is significantly larger than the overall prevalence of one percent and, given the large size of the workforce, volunteers' contribution to the care and support of adults with other needs may be considerable.

Table 5 Number, distribution and prevalence of volunteers identified in organisations providing long-term care services by main service user groups, NMDS-SC December 2010

Main service user group	Number of volunteers	% Out of all volunteers[13]	Total number of workers	Prevalence of volunteers
Older people others[14]	4,184	55.5%	365,900	1.1%
Older people with dementia	3,420	45.4%	372,438	0.9%
Older people with mental disorders or infirmities[15]	2,668	35.4%	241,130	1.1%
Carers of older people	*2,658*	*35.3%*	*93,440*	*2.8%*
Adults others	*2,588*	*34.4%*	*69,311*	*3.7%*
Adults with mental disorders or infirmities	2,403	31.9%	252,566	1.0%
Adults with sensory impairments	2,341	31.1%	245,598	1.0%
Adults with learning disabilities	2,214	29.4%	328,052	0.7%
Carers of adults	*2,109*	*28.0%*	*83,542*	*2.5%*
Adults who misuse alcohol or drugs	1,385	18.4%	126,043	1.1%
Older people with learning disabilities	195	2.6%	11,964	1.6%
Adults with dementia	132	1.8%	12,830	1.0%
Older people with sensory impairment(s)	138	1.8%	13,978	1.0%
Older people with physical disabilities	139	1.8%	18,917	0.7%
Older people with autistic spectrum disorder	113	1.5%	6,094	1.9%
Adults with autistic spectrum disorder	114	1.5%	7,616	1.5%
Older people who misuse alcohol/drugs	105	1.4%	5,700	1.8%
Adults detained under Mental Health Act (MHA)	12	0.2%	2,851	0.4%
Adults with an eating disorder	5	0.1%	2,505	0.2%
Older people detained under MHA	4	0.1%	4,006	0.1%

Roles of volunteers

The literature suggests that when volunteering takes place in organisational settings where professional staff are present, the volunteer role often augments the professional one, especially in providing companionship and information (see Neno and Neno 2007, for example). Previous research, especially from the United States, suggests that the role of volunteers within services for the older population is concentrated around providing information and transport, and other day-to-day assistance such as shopping (Baines and Hardill, 2008). Volunteers usually 'fill gaps' within the system (Butler and Eckart, 2007); they may also free some professional time to work with service users who are most in

[13] Total percent will exceed 100 percent as volunteers may work with more than one user group.
[14] Not in other categories listed in the table.
[15] Excluding learning disabilities and dementia.

need. The tasks that volunteers perform also provide insight about where and with whom volunteers prefer to spend their time and are very much linked to their motivations to volunteer their time and energy. A number of studies note that retention of volunteers is directly related to levels of satisfaction and the extent to which their expectations matched their volunteer activities (Dolincar and Randle, 2007).

The NMDS-SC data allow us to explore the exact main job roles and tasks performed by volunteers within the formal workforce providing long-term care. Of course, volunteers are present outside this formal sphere and it is likely that their tasks and roles include a variety of other activities that are not listed here. Table 6 provides a number of interesting patterns of what volunteers do within formal long-term care, as well as the relative importance of their contribution to each of these tasks. The distribution of volunteers by main job role may reflect the overall structure of long-term care tasks; for example, 22 percent of volunteers have a main role of 'care worker' and 18 percent perform 'other non-care providing job roles'. A considerable proportion of volunteers, 17 percent, were reported as having the role of 'community support' or 'outreach', perhaps reflecting the desire of volunteers to be active citizens in the larger context of community care, as identified through the literature (Attwood et al., 2003).

If we consider the relative contribution of volunteers to different job roles (by examining the prevalence, last column of Table 6), volunteers are seen to play a crucial role in tasks such as 'advice, guidance and advocacy' and 'counselling'. Volunteers constitute considerable proportions of these workforces (24% and 30% respectively). Similarly, but to a lesser extent, volunteers comprise a considerable 8 percent of the workforce whose main job role consists of 'providing education support', as identified by NMDS-SC. These particular tasks of providing guidance, support, advocacy and counselling are considered to be essential in empowering service users and enhancing their autonomy (Rapaport et al., 2006; Manthorpe et al., 2010); while at the same time these may be classified as 'soft' tasks. It is likely that other professionals, such as social workers, may also provide support and guidance to users; but with financial cuts, the increased range of their tasks and roles, and reported shortages of professional staff, it may not be feasible for the latter group of staff to dedicate enough time to these tasks. It is possible that there will be demand for volunteers to undertake this work.

Table 6 Number, distribution and prevalence of volunteers identified in organisations providing long-term care services by main job role, NMDS-SC December 2010

Main job role	Number of volunteers	% Out of all volunteers	Total number of workers	Prevalence of volunteers
Care worker	1,645	22.1%	424,151	0.4%
Other non-care-providing job roles	1,320	17.7%	14,128	9.3%
Community Support/Outreach Work	1,261	16.9%	27,648	4.6%
Administrative or office staff not care-providing	689	9.3%	29,666	2.3%
Other care-providing job roles	617	8.3%	15,690	3.9%
Ancillary staff not care-providing	565	7.6%	62,386	0.9%
Advice Guidance and Advocacy	*377*	*5.1%*	*1,600*	*23.6%*
Senior management	322	4.3%	10,549	3.1%
First line manager	169	2.3%	13,618	1.2%
Counsellor	*141*	*1.9%*	*478*	*29.5%*
Managers and staff in care-related but not care-providing roles	138	1.9%	7,580	1.8%
Educational support	*92*	*1.2%*	*1,157*	*8.0%*
Employment support	27	0.4%	1,048	2.6%
Registered nurse	26	0.3%	35,487	0.1%
Supervisor	16	0.2%	13,793	0.1%
Senior care worker	10	0.1%	50,179	0.0%
Middle management	9	0.1%	7,899	0.1%
Registered manager	8	0.1%	14,554	0.1%
Allied health professional	3	0.0%	950	0.3%
Youth offending support	2	0.0%	343	0.6%
Occupational therapist	2	0.0%	2,071	0.1%
Technician	2	0.0%	647	0.3%
Social worker	1	0.0%	30,219	0.0%

Local area characteristics and volunteering

There is no doubt that the characteristics of a local community affect volunteering through a number of interacting factors. Geography can dictate the demand, availability and accessibility of volunteering activities. For example, during the past decade volunteering has facilitated some of the delivery of health and social care services in rural England (Sherwood and Lewis, 2000; Blackburn et al., 2003). Competition, levels of employment, availability of jobs, cost of living and level of deprivation are some of the factors that may operate at a local level and affect individuals' willingness and ability to volunteer. Using the NMDS-SC data we investigate the level of correlation between different regional and area level characteristics and the prevalence of volunteering within the long-term care sector.

Region

The NMDS-SC data reveal some differences in the regional distribution of volunteers as well as the relative contribution of volunteers to the long-term care workforce in different regions. Table 7 shows that just over a quarter of volunteers are in the North West region, followed by 17 percent in the West Midlands and 14 percent in London. In terms of relative contribution, the largest is in the North West region, where 2 percent of the long-term care workforce is identified as volunteers. These variations may be related to regional effects but may also correlate with the level of responses to the NMDS-SC received from different regions.

Table 7 Number, distribution and prevalence of volunteers identified in organisations providing long-term care services by region, NMDS-SC December 2010

Region	Number of volunteers	% Out of all volunteers	Total number of workers	Prevalence of volunteers
North West	*1,973*	*26.2%*	*101,482*	*1.9%*
West Midlands	1,308	17.4%	93,789	1.4%
London	1,024	13.6%	87,023	1.2%
South West	745	9.9%	91,750	0.8%
Eastern	595	7.9%	101,532	0.6%
North East	595	7.9%	45,358	1.3%
Yorkshire & Humber	569	7.6%	64,711	0.9%
South East	491	6.5%	109,757	0.4%
East Midlands	234	3.1%	73,581	0.3%
Number of volunteers	7534	100%	768,983	1.0%

Urban/rural

It is widely accepted that rural and urban areas present different sets of challenges in recruiting for and delivering social care services (Rice and Smith, 2001). The literature abounds with research into the need for volunteers in long-term care within rural communities (for example, Wilson et al., 2005; Skinner, 2008). Some reasons for this relate to geography and space but other concerns reflect social and demographic factors, such as the outward movement of rural young people and inward movement of new groups, such as people relocating in retirement, and the associated reduction in social and family networks. At the same time, it is recognised that rural communities may face a variety of factors that may hinder volunteering.

We were able to link the NMDS-SC provision data file to a three-way classification of 'Predominantly Rural' (R50 and R80), 'Significant Rural' (SR) and 'Predominantly Urban' (OU, MU and LU) obtained for each CSSR (see Methods section for further details). For each CSSR we calculated the prevalence of volunteers out of the whole formal long-term care workforce as identified by the NMDS-SC. We then calculated the median and confidence intervals for this prevalence within the three categories of predominantly rural, significantly rural and predominantly urban. Table 8 shows that the prevalence of volunteers is on average higher among predominantly rural CSSRs (where 50% to 80% of the population live in rural settlements or large market towns); while the lowest average prevalence (0.38) is within significantly rural CSSRs.

Table 8 Median of volunteers' prevalence at CSSR level by level of rurality, NMDS-SC December 2010

	Volunteers' prevalence at CSSR level				Overall prevalence of volunteers
		Confidence Interval		Number of CSSR	
Rurality level	Median	LB	UB		
Predominantly Rural	0.52	0.04	1.08	17	1.47%
Predominantly Urban	0.38	0.26	0.50	107	1.00%
Significantly Rural	0.17	0.01	0.34	28	0.61%

Figure 2 also shows the narrowest distribution of volunteers' prevalence within significantly rural areas, indicating that the majority of individual CSSRs in this group have a comparatively low level of volunteering (this is not to say that neighbourliness or other social support is less in these areas). Predominantly urban areas varied widely and included CSSRs with a considerably high prevalence of up to 10 percent of the workforce in some CSSRs. The box plot also indicates that the prevalence of volunteering does not appear to be significantly different for predominantly rural and predominantly urban areas, when examined at CSSR level.

Figure 1 Box-plot of the distribution of volunteers' prevalence at CSSR level by level or area rurality, NMDS-SC December 2010

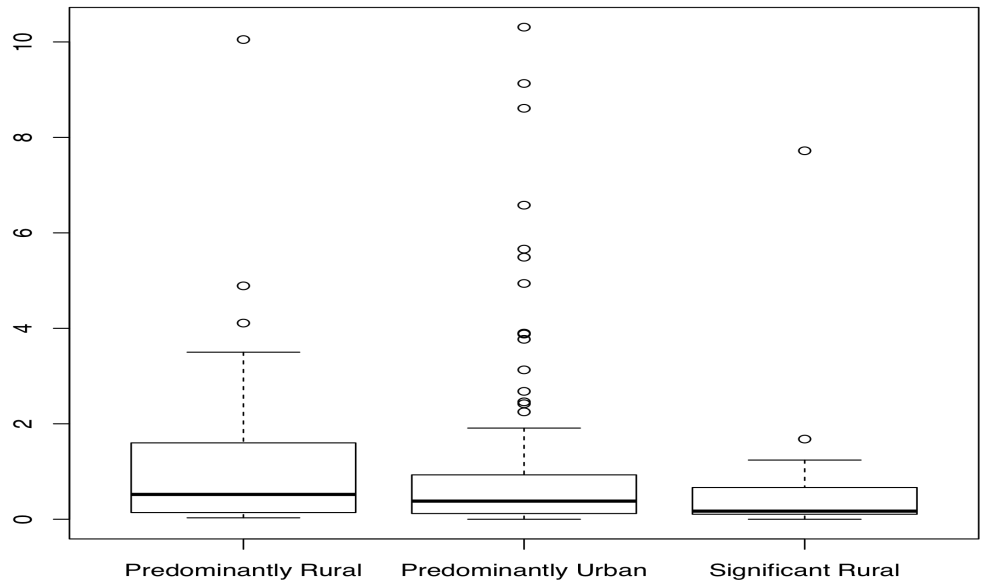


Figure 3 presents the overall prevalence of volunteers by level of rurality. The NMDS-SC Dec 2010 data show that the highest prevalence of volunteers is in predominantly rural areas, where 1.47 percent of the long-term care workforce are identified as volunteers (n=2,391 out of N= 162,170). These are the areas where 50 to 80 percent of the local population (at CSSR level) live in rural settlements, as identified by the Office for National Statistics.

Figure 2 Prevalence of volunteers by level of rurality, NMDS-SC December 2010

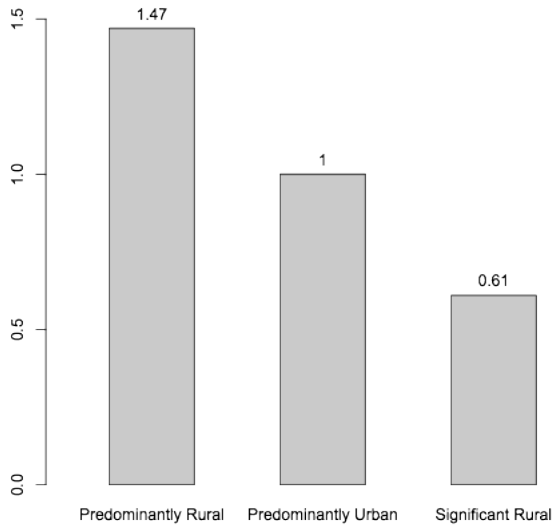


Figure 3 shows that the lowest prevalence of volunteers is found within significantly rural areas; areas where only 25 to 50 percent of the local population live in rural settlements. These findings are intriguing, posing the question of whether the relatively higher level of volunteerism observed in predominantly rural and predominantly urban areas is associated with different

sets of factors, including the make up of local populations. For rural areas volunteering may be considered an essential part in delivering health and social care services, and the local population may have different motivations to volunteer to provide long-term care, which are related to the geography and structure of their local areas. It may be the case that volunteering comprises an important source of social interaction in remote areas; and levels of volunteering may be further influenced by the availability of jobs, level of deprivation and how well-established local communities and social networks are. To investigate this further, in the next section we consider the relationships between levels of volunteerism in formal long-term care provision and local area deprivation indices.

Local area deprivation indices

As explained in the Methods section, we linked the NMDS-SC provision data file to the English Indices of Multiple Deprivation (IMD 2007)[16] on a small spatial scale called the Lower Super Output Areas (LSOAs). The IMD is made up of seven LSOA level domain indices. There are also two supplementary indices (Income Deprivation Affecting Children and Income Deprivation Affecting Older People).

Figure 3 Scatter plot of prevalence of volunteering in LSOAs by Average multiple deprivation score, NMDS-SC December 2010 and IMD (2007)

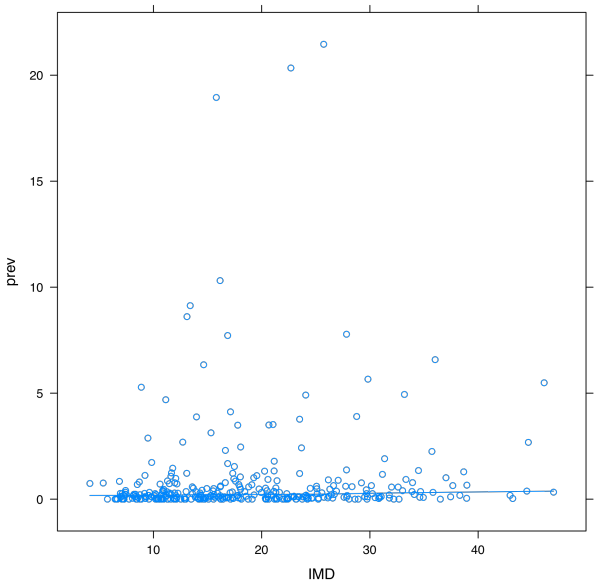


Figure 4 presents the relationship between the prevalence of volunteering in the formal long-term care sector in England and the average multiple deprivation score for each of the LSOAs. The graph indicates that on a very local level the prevalence of volunteering (presented in small blue circles) ranged from just above zero to over 20 percent of the long-term care workforce in some LSOAs. The scatter plot (and a fitted linear line) does not show any clear relationship between the average IMD score at LSOA level and the prevalence of local volunteerism. Figure 4 shows that even in areas where deprivation levels are relatively high, the prevalence of volunteerism reaches over 5 percent of the formal workforce. It is clear from the data that a considerable number of LSOAs indicated having no volunteers and this is related to the huge number of employers which reported no volunteers at all in the NMDS-SC data return. It is likely that some of the information provided by employers may not accurately reflect the exact contribution of volunteers. There is always the chance that some employers may not report volunteers as part of their workforce, either due to a

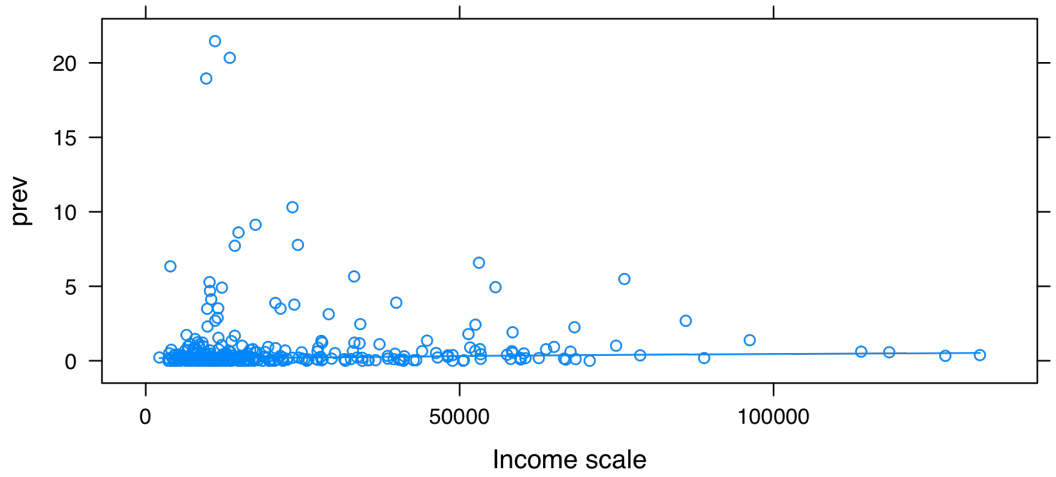
[16] The higher the IMD value the more deprived the local area.

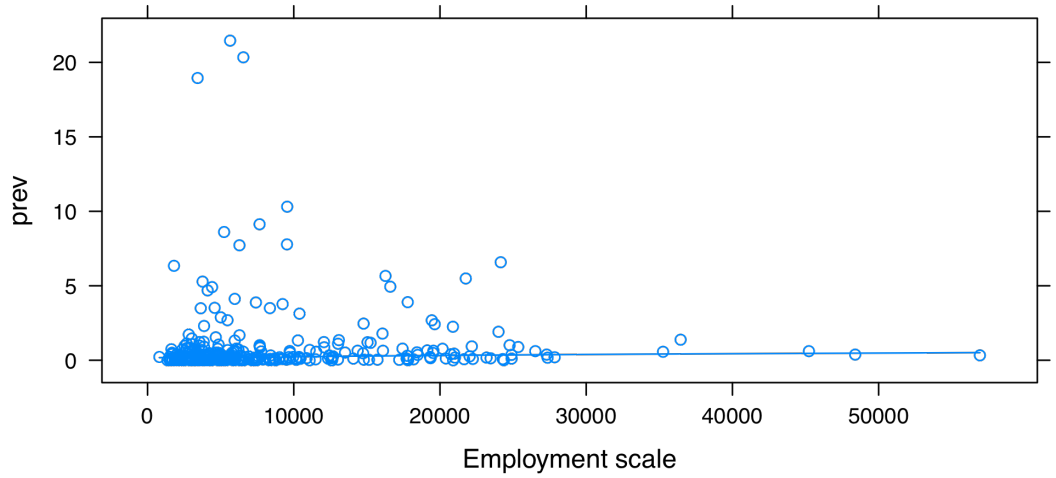
misinterpretation of questions in relation to what constitutes 'workforce', or to the nature of volunteers' contribution to the workplace and the regularity and pattern of that contribution. There is no easy way to further investigate these suggestions using the NMDS-SC, but the observations in relation to the large number of organisations with no volunteers at all may indicate an underestimate of the calculated contribution of volunteers to the English formal long-term care workforce using NMDS-SC.

We further explored the relationship between some elements of IMD (2007) and volunteering in local areas. We focused in particular in two sub-scales: the employment and income scales. The purpose was to gain further insight into the relationships between local wealth/poverty (income) and availability of human capital (level of employment) and volunteering in the local formal long-term care sector. The income deprivation domain of the IMD captures the proportions of the population experiencing income deprivation in an area from proxy indicators based on benefit receipt (e.g. income support, income-based job seekers' allowance etc.) (Noble et al., 2008). 'Employment deprivation domain' measures employment deprivation, defined as involuntary exclusion of the working-age population from the world of work. This scale is calculated in relation to a number of labour measures, such as receipt of jobseekers' allowance, participation in the New Deal for the 18-24s, incapacity benefit and others (for full details see Noble et al., 2008).

Figure 5 presents scatter plots of the relationships between level of volunteering and both income and employment scales (IMD 2007) on an LSOA level. It shows no clear correlation between prevalence of volunteering and income or employment scales on a local level; and yet points with a high prevalence of volunteering (10 percent or more of the formal LTC) are observed in LSOAs with better income and employment scales. It is important to note the correlation between income levels and receipt of employment-related benefits (see bottom-left corner of Figure 6).

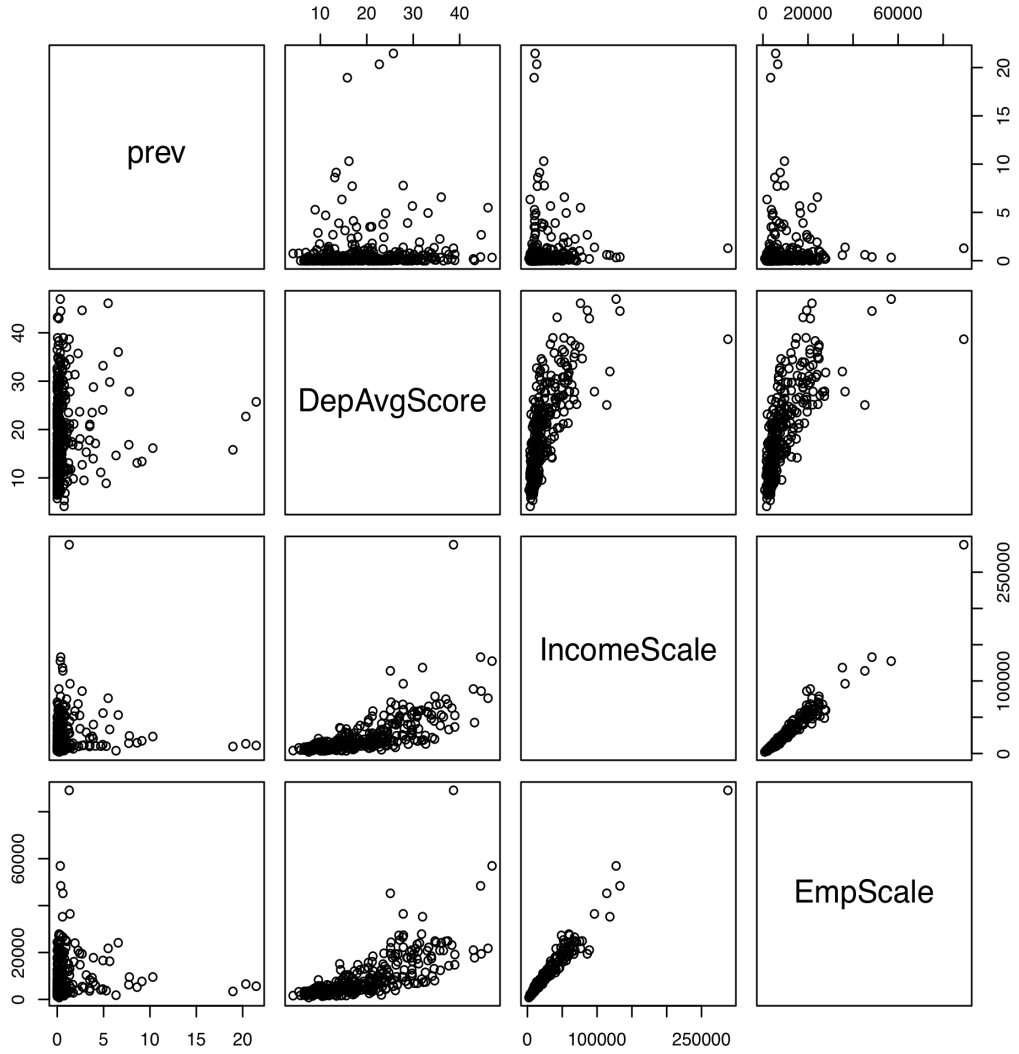
Figure 4 Scatter plot of prevalence of volunteering in LSOAs by income and employment scales[17] , NMDS-SC December 2010 and IMD (2007)





[17] The higher the value the more deprived the area in terms of income and employment.

Figure 5: Associations between IMD (average deprivation score) and each of the income and employment scales as well as the prevalence of volunteers



Personal profile of volunteers in long term care

A 'volunteer' has traditionally been visualised as a female of middle years and middle to upper income who has not had a career outside the home (Davies Smith, 1993). In the past it has often been assumed that volunteering usually takes place during daytime hours, perhaps when children are in school. However, recent research indicates that volunteers include people of all ages, including the very old, and of all races, religions, careers, and socio-economic groups (Wardell et al., 2000; Skinner, 2008; Hank and Erlinghagen, 2009).

We expect some correlation between the personal profile, motivation and experience of volunteers, the type of voluntary work undertaken, and the specific 'clients' or users served. It is argued within the care sector that volunteers' involvement tends to reflect their personality, experience, and personal circumstances linked to care: such as caring for older parents (Wilson et al., 2005). There are some assumptions that volunteer carers (caregivers) tend to be the same age as their clients, so that peer relationships are developed (Omotto et al., 2000). Beyond peer relationships, some volunteers have experience, which is transferable, and some anticipate the circumstances of the person served. Conversely, volunteers with older people are sometimes those who in their middle years anticipate getting older and feel empathetic to the difficulties that vulnerable older people face.

In this section we explore the personal profile of volunteers within formal long-term care in England, using the NMDS-SC individual workers' file (December 2010). Employers completing the NMDS-SC provide detailed information on all or some of their workers. Using the 'individual workers' dataset, we identified 704 workers identified by employers as volunteers. This is a small sample of the total volunteers identified within the provision data file (9.3%); we use this sample of volunteers to investigate their personal profile and compare their characteristics to the overall social care workforce characteristics, as examined in earlier Issues of this Periodical.

Ethnicity, gender and age of volunteers

Among the 704 volunteers, 87 percent were identified by employers to be of white ***ethnicity***. This is larger than the average of 82 percent for the whole social care workforce in England (Hussein, 2009), but similar to the general population. There were equal proportions of 5 percent of Black or Black British and Asian or Asian British workers among the volunteers; while a larger proportion than average were identified to have any form of ***disability*** by their employers (13.2%, vs. 2%). We can interpret this finding as showing that those with disabilities may be more likely to volunteer than to commit to a more formal work arrangement; while at the same time, formal long-term care workers may be less likely to inform their employers of any form of disability, for fear of losing all or part of their jobs.

Some of the distinct characteristics of volunteers when compared to the overall long-term care workforce are related to both gender and age. In terms of ***gender***,

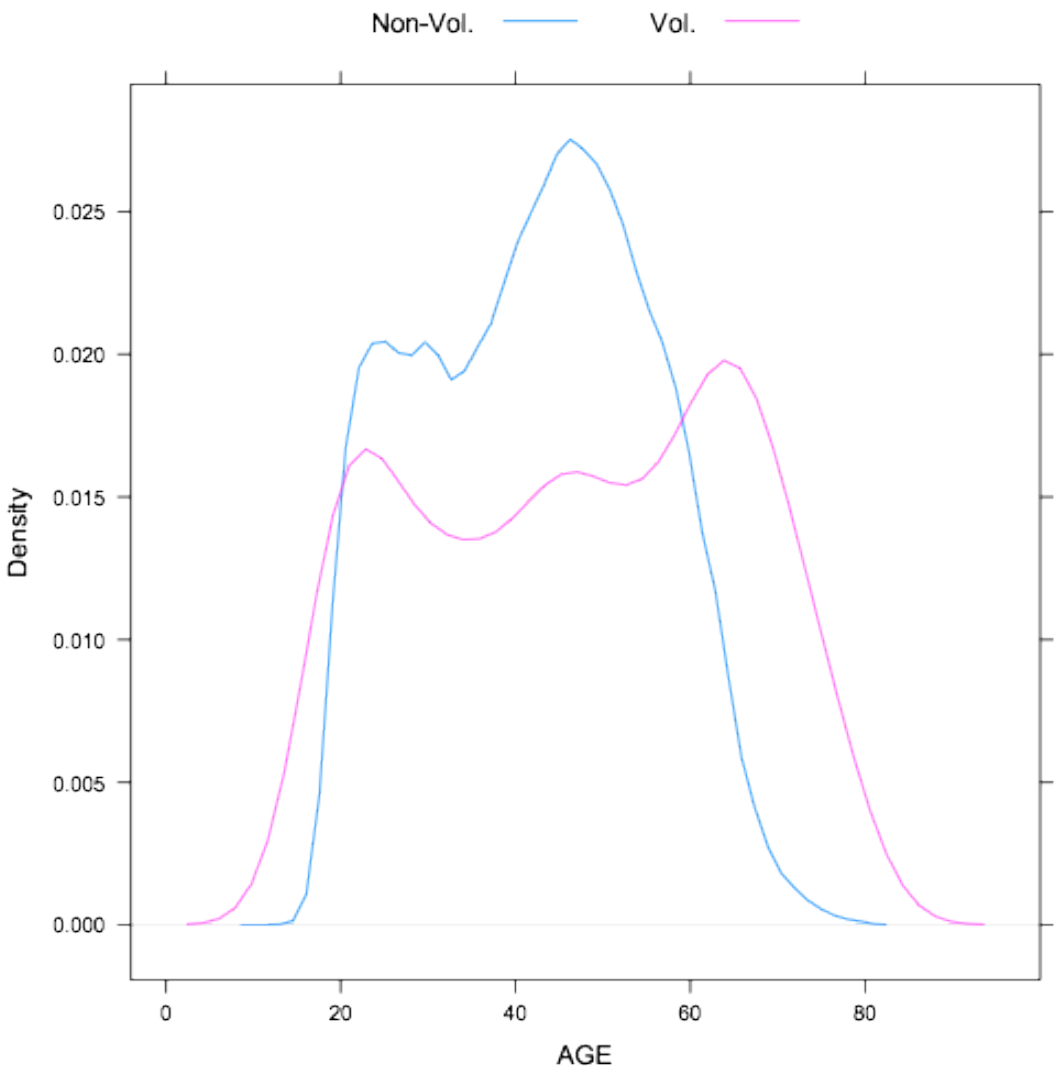
volunteers are more likely to be men. Over a third of the volunteer sample identified through the NMDS-SC were male (33.6%, n=232). This is a particularly interesting finding as the vast majority of the paid long term care workforce is women (Hussein, 2009). The median ***age*** of volunteers was also significantly higher than the rest of the workforce at 48 years (mean age=47 years), compared to 43 years (mean age=42 years) among non-volunteers. Table 9 shows that the sample of volunteers contains proportionally more people of older ages (65 years or more) and relatively more people aged 70 or more. For example, 24 percent of volunteers are aged 65 or more compared to only 3 percent of the rest of the workforce. To a lesser extent, volunteers included proportionally younger people than the rest of the workforce. For example, 7 percent of volunteers are 19 years old or younger compared to 2 percent of the rest of the workforce.

Table 9 Distribution of volunteers and non-volunteers by age groups, NMDS-SC December 2010

	Volunteers		Rest of the workforce	
Age group	%	N	%	N
Under 18	1%	6	0.3%	1,631
18 to 19	5.6%	34	1.7%	9,530
20 to 24	10.0%	58	9.4%	53,041
25 to 29	7.4%	45	10.0%	56,547
30 to 34	6.5%	40	9.8%	55,407
35 to 39	5.6%	34	10.5%	59,399
40 to 44	7.2	44	12.5%	70,678
45 to 49	8.8%	54	13.6%	76,577
50 to 54	7.0%	43	12.4%	69,750
55 to 59	7.7%	47	10.0%	56,470
60 to 64	10.0%	61	6.5%	36,703
65 to 69	10.5%	64	2.3%	12,855
Over 70	13.3%	81	0.8%	4,690
Total	100%	611	100%	563,278

Figure 7 shows the density plot of the distribution of age for volunteers and non-volunteers. It is clear from Figure 7 that the distribution of age among volunteers (the pink line) is more uniform than for the rest of the workforce. There is a smooth distribution of ages among volunteers with a slight peak among younger ages (<20) and a more evident peak at older ages (65+). For non-volunteers, however, there is a significant concentration around the middle age-groups (45-55). On average, male volunteers were one year younger than female volunteers in the sector (median age of men=47.5; for women=48.5).

Figure 6 Density function plot of the distribution of volunteers' and non-volunteers' age, NMDS-SC December 2010



Qualifications and induction

Overall, 18 percent of volunteers were reported as holding no qualifications; and 56 percent of those with any qualifications held qualifications not relevant to the care sector. This can be seen as maximizing the contribution of social capital: not holding relevant qualifications does not, as a matter of course, constitute a barrier to volunteering. This is confirmed by the fact that nearly three-quarters of volunteers (72%) have completed (or are in the process of completing) an induction course.

Nationality

Employers indicated that 14 percent of volunteers are non-British; this is slightly lower than the 16 percent contribution of migrants within the social care workforce as a whole (Hussein, 2011). In terms of where these migrants came from, employers provided the nationality of 51 non-British volunteers, with the majority identified to be German (10) followed by Irish (n=6); 5 being from Nigeria, 4 from Korea and India each and one or two from a number of other countries (see Table 10). It is not possible to deduce any pattern of association between specific non-British nationality and being a volunteer, due to the very small number of non-British volunteers about whom there was information on nationality.

Table 10 Distribution of non-British volunteers by nationality, NMDS-SC December 2010

Nationality	Number of volunteers
Germany	10
Ireland	6
Nigeria	5
India	4
Korea	4
Austria	2
Italy	2
Kenya	2
Pakistan	2
Poland	2
United States	2
Angola	1
Australia	1
Brazil	1
Taiwan	1
Georgia	1
Finland	1
Hungary	1
Indonesia	1
Philippines	1
Somalia	1
EEA	22
Non-EEA	29
All	51

Recruiting volunteers

Volunteering or 'helping out' in the community can bring a number of social, psychological, and mental benefits. Volunteering is of particular importance to the long-term care sector with the current intersection of financial, social and policy changes. Research shows that volunteers are likely to continue such activities once they gain these positive benefits. Thoughtful recruitment and screening of the volunteers can be critical to both the service provided and the retention of volunteers. Depending on the motivations of volunteers, self-selection also plays an important role in volunteering. When working with older people, Vance and colleagues (1993) found that elderly clients prefer volunteers who are prompt, friendly, and kind; they did not emphasise relevant experience or other characteristics.

The literature suggested that volunteer recruitment and retention can be a challenge due to an increasing number of interacting factors, including financial cuts, governmental support to voluntary organisations, the increasing need for community involvement and new notions such as the Big Society, alongside an observed decline in civic engagement (Putnam, 2000; Skoglund, 2006).

There is considerable literature on the motivation and recruitment of volunteers in general. For example, much of the research demonstrates that volunteers from various population segments are likely to differ with respect to the motivations, needs and interests which prompt them to volunteer. Most of the research on motivations, recruitment and related issues has focussed on volunteers, with very little on people who are not currently volunteering but may wish to volunteer. To summarise the literature, six main motivational groups are identified in relation to volunteering:

1. Values: volunteers may be acting on deeply held beliefs about the importance of helping others.
2. Understanding: desire to learn about others and oneself from participating in volunteering work.
3. Career: a means of enhancing one's employability or career.
4. Social: to satisfy the influence of significant others (e.g., family).
5. Esteem: people who feel good about themselves will feel even better from volunteering.
6. Protective: people who are lonely will volunteer to escape this feeling.

These categories suggest a continuum of motivations from altruism to self-interest, and it is important for long-term care providers to understand the spectrum of volunteers' motivations. The NMDS-SC does not provide any data on volunteers' motivations to work in the long-term care sector; however, it does provide information on the source of recruiting volunteers. Employers provided the source of recruitment for 437 volunteers. Table 11 shows that the majority, 69 percent, of volunteers were reported as having been recruited through 'volunteering or voluntary work'. It is difficult to establish from this what this means; it might possibly indicate recruitment from existing volunteer groups; or perhaps this group reflects 'new' or 'returning' volunteers. The data also show that a small proportion of volunteers (12%) are recruited from within the social care sector. These may be social care workers who have retired or other workers who hold a part-time care job while volunteering some of their time in the same or another organisation. The remaining volunteers, 19 percent, are recruited from other sources, including other sectors; were not previously employed; or were from abroad.

Table 11 Source of recruiting volunteers, NMDS-SC December 2010

Source of recruitment	Distribution	Number
Volunteering or voluntary work	69.1%	302
Social care sector	12.4%	54
Other sectors	4.6%	20
Other sources	9.2%	40
Not previously employed	2.1%	9
Student work experience or placement	1.8%	8
From abroad	0.9%	4
Number of volunteers	100%	437

Discussion

The current analyses and associated findings provide a unique insight into the contribution of volunteers in the formal long-term care sector in England. Bearing in mind that volunteering in formal settings is one of the highest levels of civic engagement, the data point to the considerable contribution of volunteers to the sector. Overall, volunteers are estimated to constitute just one percent of the overall long- term care workforce; however, there are questions around the accuracy of reporting. Indeed, this highlights the opportunity to engage more volunteers in the sector. Within organisations with any volunteers, the contribution of volunteers becomes much more significant: they constitute over a quarter of the workforce. Volunteers seem to be attracted to small to medium size organisations but appear to be scarce in large organisations, even in the voluntary sector. These findings may lend support to the argument of Milligan and Fyfe (2005), who suggested that the process of enlarging voluntary organisations hinders the recruitment and retention of volunteers.

One important finding is the significant and distinct role volunteers play within formal long-term care provision. Some job roles mainly related to providing support, advice and advocacy are often undertaken by volunteers. While volunteers in the sector work with a wide range of service users, they are over-represented in services aimed at carers (of adults and older people).

There were no clear relationships observed between local area deprivation levels and prevalence of volunteers; however, a tentative finding was that areas with the highest levels of volunteering were the wealthiest in terms of income and employment scales. Volunteers were relatively more common in predominantly rural areas (where 50 to 80 percent of the local population live in rural settlements).

Volunteers were on average significantly older than the formal long-term workforce, yet they contained relatively larger proportions of younger people (19 years or younger). Men were also over-represented amongst volunteers and tended to be younger than women. This points to the potential for recruiting volunteers from outside the traditional profile of social care workers. There appears to be a possibility of attracting volunteers from a wider range of people, in terms of gender, age and social background, than are currently recruited to the formal workforce.

In terms of the source from which volunteers were recruited, the majority of employers indicated that this was through ‘voluntary work’; but it was not clear how the process of recruitment was achieved. Some volunteers are recruited from within the care sector, which may reflect workers who are retired and who wish to prolong their engagement within the sector. Like many of the findings in this Issue, there would appear to be scope to investigate this further by collecting more tailored information.

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